South Carolina Care Call

Telemonitoring

Users' Manual

South Carolina Department of Health and Human Services
Community Long Term Care – Waiver Management

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February 1, 2010

Section 1 – Introduction

The South Carolina Division of Community Long Term Care (CLTC) has developed User's Manuals to provide instruction and reference for providers who use Care Call. These manuals are available from the link labeled Care Call Manuals on the Care Call website at https://scc.govconnect.com. These manuals coupled with training provided by CLTC and careful attention to both the instructions on the Interactive Voice Response System (IVRS) and each web screen enable providers to perform Care Call's routine functions.

If questions remain after review of the User's Manual, contact CLTC via email at carecall@scdhhs.gov or by phone at 803-898-2590.

1.1 Background

The Care Call system is an automated system used for service documentation, service monitoring, web-based reporting, and billing to MMIS. For documentation of Telemonitoring services, providers call a toll free number to document service delivery or document service delivery via the Internet. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately.

For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

1.2 How does Care Call Work?

Care Call is based on simple principles.

1. The provider delivers the service that has been prior authorized.

2. The provider uses a touch-tone phone to call the toll-free Care Call number or the web to record the number days Telemonitoring was completed.

3. From that IVR or the web entry, Care Call generates a claim that is submitted electronically to MMIS for processing.

4. Claims are submitted for processing weekly on Sunday. Payment is made directly to the provider.

5. The provider uses the web to run reports that monitor services being provided, claims submission and payment by MMIS.

Section 2 – How to Use the Care Call Website

2.1 Getting Started
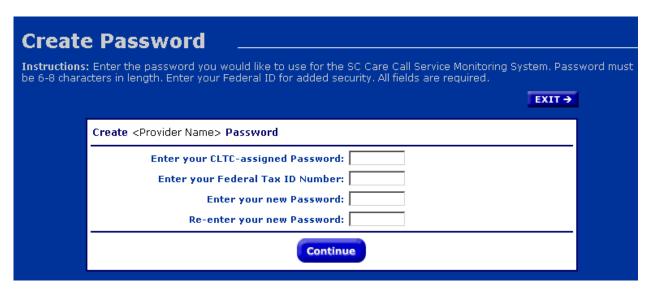
To use the Care Call Website, the provider needs
1. Access to the Internet,
2. For first time users, their Provider ID, password, and FEIN
3. For repeat users, their Provider ID and password.

The Care Call website is https://scc.govconnect.com.

The Welcome screen below is the first Care Call screen. The first time the provider uses the website, you must enter your Provider ID in the Provider Log In section under "I am a new user (I need a password)". Press Create Password.

The next screen requires you to enter your CLTC assigned password, Federal Tax ID number, and a new password and then click Continue.

(If you do not know your CLTC assigned password, contact Community Long Term Care at 803-898-2590.)

The next screen indicates you have successfully created a new password and can now use the website. Pressing Continue takes you to the Main Menu.
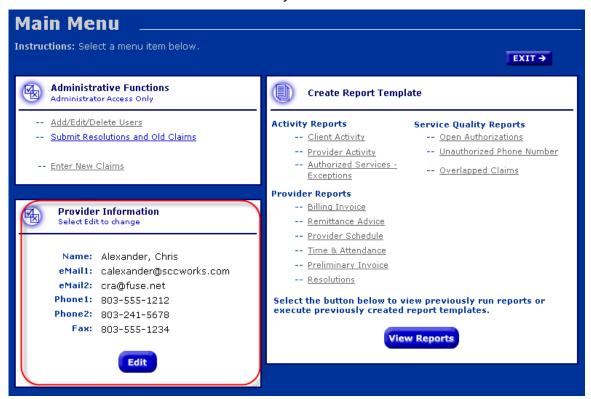
Please make a note of your password and save it in a safe place. If you lose your password, you must call FDGS Client Services at 1-800-747-1374; press 2 for Client Services.

You will only need to set up your agency as a user one time. In the future, you will enter your ID and password from the Welcome Screen under Provider Log In to access your Care Call information. A provider user can only see information specific to the clients assigned to that provider.

2.2 Maintaining Your Provider Information

On the lower left side of the Main Menu is your Provider Information.
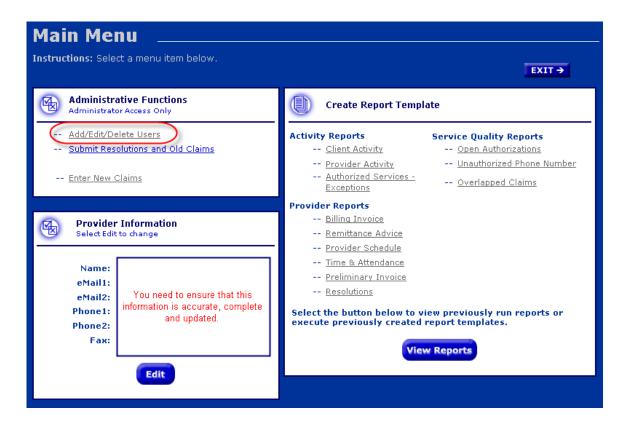
It is the place to record the contact information for your agency. The first time you sign on to the website, it will be prepopulated with the information Care Call has in its database for your agency or provider group. Please check the information to assure that it is complete and current.

This information will be used by CLTC to quickly communicate with you and give you information of importance to your agency. Examples include problems with the Care Call IVR System, changes in payment dates and other programmatic information. Please be sure that you keep your contact information updated so you can receive this information quickly.
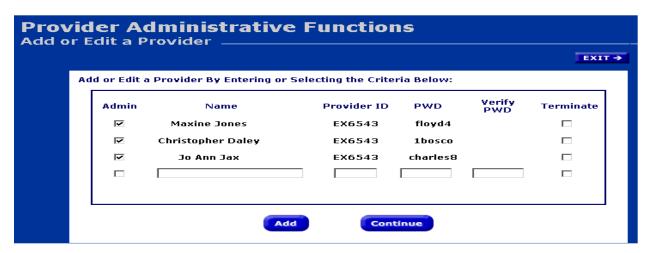
To add or change any of the information, click on the Edit button. Care Call will allow you to edit each field except the Name field. When you have finished, click on Save and your provider information will be updated on the Menu Screen.

2.3 Adding Other Users from Your Agency

Many people within an agency can use the website. You can create other users at any time from the Main Menu by selecting Add/Edit/Delete Users.

You will see the following screen:
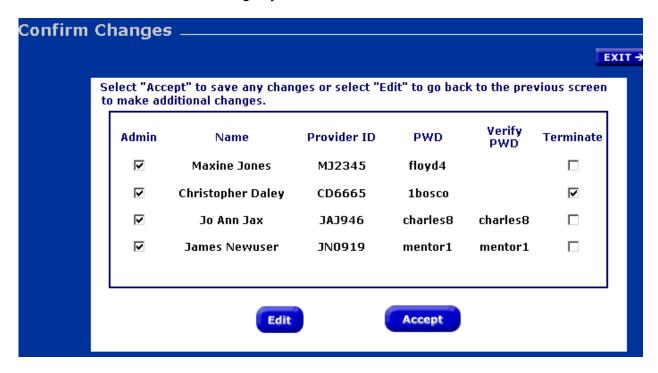
This screen lists each person at your agency who is able to use Care Call via the web and a blank line for you to add another by entering his name and password.

Considerations with this screen:
- Checking Admin allows the worker to create other users, do claims resolution and run reports. It is important to remember that when you give a worker administrative rights, that worker can update the information for all other users in your agency. Only give these rights to workers in your agency who need them.
- If the worker only needs to run reports, do not check Admin.

- **When a worker no longer needs access to Care Call, use this screen to terminate their password and Care Call access.** If the user leaves your agency, they will still have access to your information unless you terminate their password.

Click Continue to confirm the changes you have made to web users:

Confirm Changes

Select "Accept" to save any changes or select "Edit" to go back to the previous screen to make additional changes.

Admin	Name	Provider ID	PWD	Verify PWD	Terminate
☑	Maxine Jones	MJ2345	floyd4		☐
☑	Christopher Daley	CD6665	1bosco		☑
☑	Jo Ann Jax	JAJ946	charles8	charles8	☐
☑	James Newuser	JN0919	mentor1	mentor1	☐

Edit   Accept

When training your agency's users, please assure that they understand what functions they are authorized to perform on the web and that their status (admin or not) determines the screens that are displayed when they log in to Care Call.
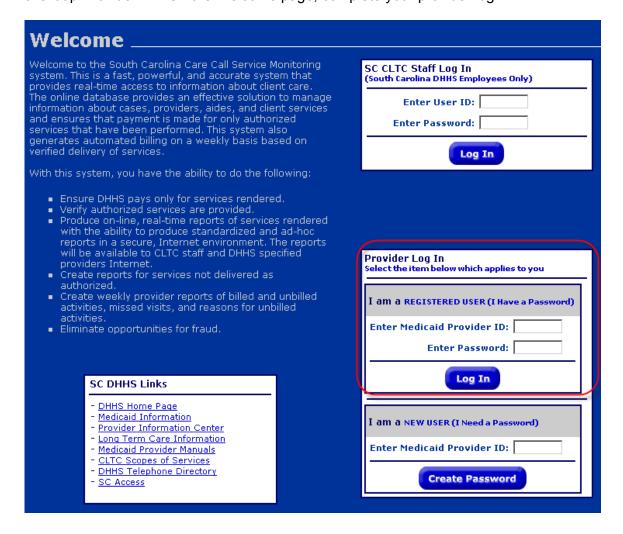
Section 3 – Entering Claims via the Web

To use the Care Call Website, the provider needs
1. Access to the Internet,
2. Their Provider ID and password
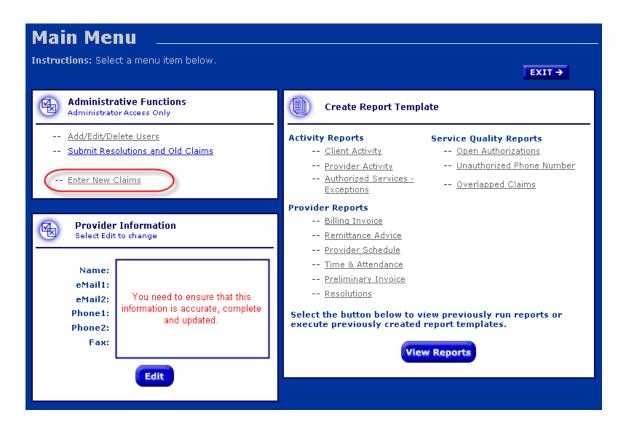
The Care Call website is https://scc.govconnect.com.

To enter claims via the web, the user must log in with a regular Provider ID and not with a Group Provider ID. On the Welcome page, complete your provider log in:

When you log in, you are automatically taken to the Main Menu, click on Enter New Claims.

On the next screen select the service and date range you would like to enter claims for. Claims for Telemonitoring services can be entered for the current week and the previous five weeks.

The next screen (shown below) will list each client authorized to receive service for the week you entered.

- If you provided service to the client indicate the number of days under units and "save" under action.

- If you need to add a claim for a client who is not listed, select the Add Claim button and another line will appear with the client field blank. Enter the client's CLTC #, the number of days under units and "save" under action.

Selecting Calculate Total Units will display the number of Telemonitoring units you indicated were provided for the specified week.

When you have finished adding all claims, press Record Claims and you will see the Confirmation screen that lists each claim you have entered and saved.

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Section 4 – Entering Claims Using the IVRS

To use the Interactive Voice Response System (IVRS) (Care Call Phone System), the provider needs
1. Access to a **touch-tone** telephone,
2. The Provider ID number and PIN,
3. Knowledge of number of days Telemonitoring service was provided for each client, and
4. Each client's CLTC number.

The Care Call telephone number is **1-888-978-2273**.

Sample script with no errors:

Care Call	Provider Response
Welcome to the South Carolina Care Call Voice Response System. To continue this call in English press 1.	**Press 1**
To check-in, press 1. To checkout, press 2.	**Press 1 if you want to enter clients that received Telemonitoring**
Please enter your eight-digit South Carolina Care Call Worker ID. To return to the main menu press the pound (#) key.	**Enter your CLTC provider ID (not including EN or EX) and 9999**
Please select from the following list of services. To enter claims for Telemonitoring , press 1	**Press 1**
Please enter your personal identification number or PIN.	**Enter the Care Call IVR PIN that has been given to you by CLTC.**
Please select the week that you would like to enter claims for. *(Care Call will list the current week and the last four weeks.)*	**Press 1, 2, 3, 4, or 5**
(After entering the week you would like to enter claims for, Care Call calls back the clients that are authorized to receive service during the time period specified.) For (client's name), please enter the number of units you delivered followed by the pound (#) key.	**Enter the number of units delivered for that client and then the pound (#) key.**
(After the IVR has called back all the clients authorized for the time period, the following phrase plays) If you are finished entering claims, press 1. To enter a client that has not been listed, press 2.	**If you press 2,**
Please enter the client's seven digit CLTC number	**Enter client's CLTC #**
If the client is (client's name), press 1, if not press 2	**Press 1, if the correct name is played**

For (client's name), please enter the number of days you delivered service followed by the pound (#) key.	**Enter the number of days service was delivered and then the pound (#) key.**
If you are finished entering claims, press 1. To enter a client that has not been listed, press 2.	**Press 1, if you are finished, pressed 2 to enter additional clients**
To hear and verify the list of entries you have made during this call, press 1, to save claims and end this call press 2	**Press 1 to verify or press 2 to end the call**
*(If you **press 1**, the following phrase will play for each client that you indicated received services for the time period.)* You have indicated that (client's name) received ___ units. If this is correct press 1, if this is not correct press 2	**Press 1, if the client received the Telemonitoring as stated.**
*(If you **press 2**, the following phrase will play)* Your claims have been successfully recorded.	

It is very important to hear "Your claims have been successfully recorded" before hanging up the phone. This phrase indicates your call was successful and claims will be submitted to MMIS for payment.

If you encounter any problems using the system, send an e-mail to carecall@scdhhs.gov.

Section 5 – Claims Resolution
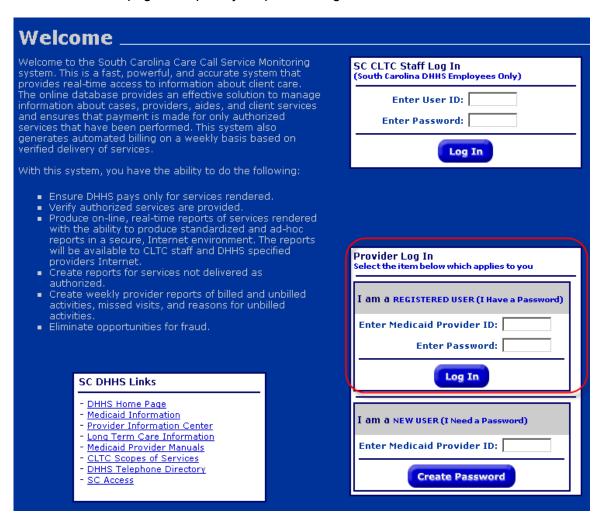
Providers can add claims to Care Call during the normal process by phone for the current week and the previous four weeks or on the website for the current week and the previous five weeks. If a claim is not added through the normal process, the resolution process, as allowed by CLTC policy, must be used. The claims resolution process is only for claims being submitted to MMIS for payment. Claims not added within the six week period allowed for web access are considered "old claims". Claims resolution can be done for dates of service back one calendar year.
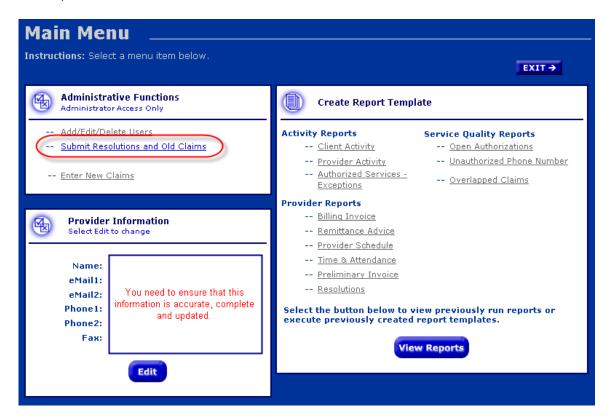
To use the Care Call Website, the provider needs
1. Access to the Internet,
2. Their Provider ID and password
3. Information on missing claims

The Care Call website is https://scc.govconnect.com.

On the Welcome page, complete your provider log in:

When you log in, you are automatically taken to the Main Menu screen where, to add old claims, click on Submit Resolutions and Old Claims.

From the Main Menu, the user will first access the Resolution Search screen seen below:

The provider ID will be prepopulated unless a Group Provider ID has been used to log in. If a Group Provider is logged in, the user must select one of the Provider ID's in the

Group from the dropdown box.   The user must also select the appropriate service from the drop down box.

When you click on the Add Resolution button, the Add Old Claim(s) screen appears:

To add a claim, you must enter the following information:
- The client's CLTC #,
- Units provided
- Date of Service
- Reason (from the drop down)
  - Care Call not functioning
  - Forgot to file claim
  - Not submitted to MMIS
  - Claims not entered timely
- Action
  - Blank (claim will not be submitted)
  - Submit

If there are additional claims to add, click on the Add Claim button for each additional line needed.   Clicking the Calculate Total Units button will display the number of claims you have entered.

When you have finished adding claims, click Continue and you will see the screen below which allows you to verify the claims that were added.

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Note that a claim added through this resolution process is not assigned a claim number until reviewed and accepted by CLTC. If the information on this screen is not correct, you can click the Edit Changes button to revert to the Add Old Claims screen for additional changes.

When you click on Submit, you will see the confirmation screen that you can print for your records.

The CLTC regional office will be automatically notified through Care Call when you submit resolutions to be processed. They will research the resolution to determine whether to accept or reject.

You can check on the status of the processing of the Resolutions by running a Resolutions report for the date(s) of service. If a Resolution is accepted by CLTC, the claim will then appear in the regular claim reports. This report is described in more detail in Section 6 of this manual.

Section 6 – Reports
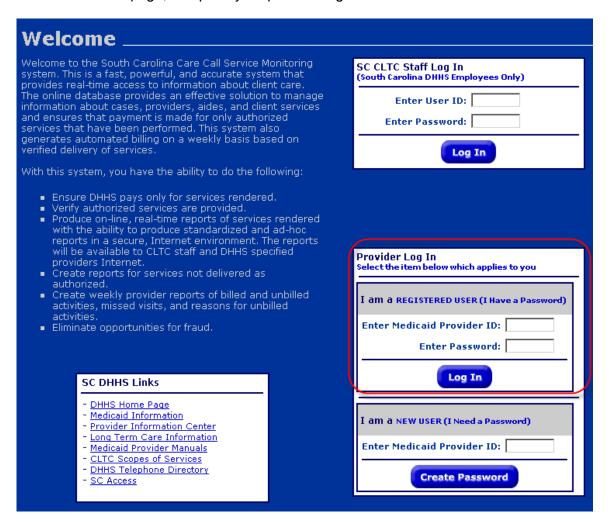
Included in Care Call are multiple reports that providers can use to review and manage their activities. These reports are accessible via the web at any time and contain real-time, current information that can be displayed in four different formats: HTML, Excel, Word or PDF.

To use the Care Call Website, the provider needs
1. Access to the Internet,
2. Their Provider ID and password
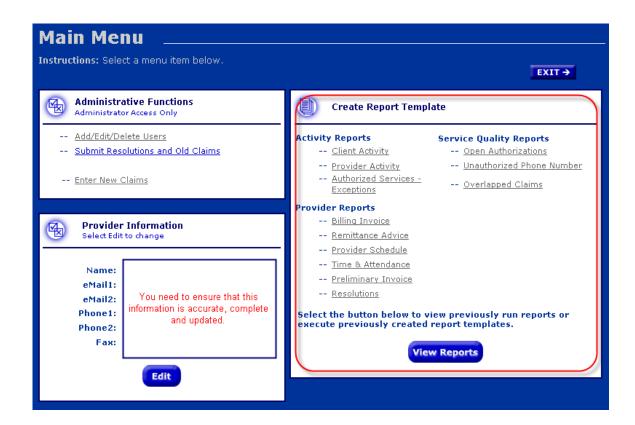
The Care Call website is https://scc.govconnect.com.

On the Welcome page, complete your provider log in:
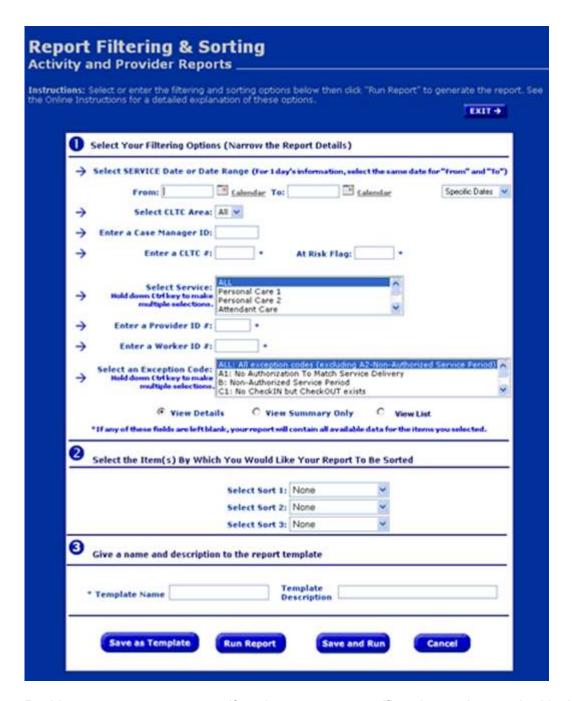
When you log in, you are automatically taken to the Main Menu screen where each report type is listed.

Select the report you want to run by clicking on the title or click on the View Reports button is you want to see a previously run report or execute a previously created report.

If you click on a specific report, the next screen displayed will be the Report Filtering and Sorting screen. Most reports have a filtering and sorting screen like the one shown below:

By this screen, a user can specify a date range or specific values to be matched in the Care Call database for inclusion in the report. Depending on the report, uses have a Detail, Summary or List View of the report data. On most reports the user can select custom record sorting (though users should b aware that grouping in the reports overrides the sort criteria).

NOTE: Some reports have their own unique Filtering and Sorting screen that may be different from the example above. Users must pay careful attention to the available criteria as well as the View formats listed for the report.

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After selecting your report criteria, you can Save as a Template, Run a Report or Save and Run. When you make your selection, a screen similar to the one below will appear:

On the left side are any Report Templates you have saved. Many users find this feature helpful if they need to routinely run reports with the same filter and sort criteria. You can also edit parts of the report, such as the date range or worker ID. Click on the name of the template to open and run it.

On the right, are the reports in progress and recent reports that have been run in the last three days. The first one on the list, when you first access this screen will show the Status as "in process" and the Status will change to complete when the report has collected the data you specified and is ready for your review. Click on the appropriate icon for the report to open the report for viewing, saving to your hard drive or printing. From this page, the user can return to the Main Menu or Exit Care Call.

This manual will provide a brief description of the reports available to providers. Only by using them can the provider determine which best meet his needs and obtain the full benefit from the robust reporting capabilities Care Call offers. It is important to remember that reports are available on demand (unless otherwise noted) and contain current, up-to-the minute information.

The following details only the reports that can be utilized by Telemonitoring providers:

6.1 Client Activity Report

Known as the "core report", the Client Activity report contains all services provided in a given time period, specifying the overall picture of the service that was provided from the time the worker arrives at the client's site through submission of the claim and payment to the worker or Agency. It includes all relevant information related to the service delivery (worker, client, units, date/time and any exceptions). The report can be grouped and sorted using several different criteria including case manager, client, worker and date of service.

6.2 Exception Report

This report displays claims for which exceptions are indicated. The user may select all exceptions or any subset of exceptions for all or any subset of services. Included in the report is the ability to list missed visits or the absence of a claim for a visit that was authorized and should have been made. Exceptions are used to readily identify claims that do not meet the business rules established by CLTC for the program. Exceptions are discussed in more detail in the last section of this manual.

6.3 Resolutions Report

The Resolutions Report shows claim resolutions submitted by providers along with CLTC status and disposition. It is used to view and check status of claim corrections.

6.4 Preliminary Invoice Report

This report is designed to provide detailed information about claims that were and were not submitted to MMIS for processing. It includes
- Claims that were submitted to MMIS for processing and payment, regardless of when they were entered into Care Call.
- Claims entered since the last claim submissions that were not submitted to MMIS due to some critical exception condition.

This report is made available via the web every Sunday. This replaces the e-mail report that providers have been receiving. **It is important that you run this report each week if you want to have the preliminary invoice information.   A history of this report is not maintained on the web; only the current report is available.**

6.5 Billing Invoice Report

This gives a list of claims for each service date, along with the MMIS billing status and amount. With this report, providers have documented what was submitted for payment each week and then monitor the Remittance Advice to ensure that each claim was adjudicated as expected.

6.6 Open Authorizations

This report lists all open authorizations for the provider. Open means that the authorization has a Start Date before the selected Date of Service, and the End Date is either after the Date of Service or the End Date is blank. The report includes information about the client, the date authorized, the service, and the authorized units. The report also can display either all open authorizations, or only duplicate pairs of authorizations: authorizations issued, perhaps at different times that overlap on the Date of Service.

6.7 Remittance Advice Report

This report allows the provider to download the electronic remittance advice that is generated by MMIS on a weekly basis.

6.8 Provider Activity Report (Worker Activity Report)

This report lists by worker all services performed during a given time period and the total dollars billed to MMIS for that worker.

Section 7 – Exception Codes

7.1 Initial Exception Codes

Care Call assigns an Exception Code to a claim that does not meet all the established criteria for a "clean claim". Providers should run Exception Reports routinely to identify and address claims needing resolution to assure that all services provided are submitted for payment in a timely manner.

Because claim data displayed in reports is real time, exception codes can change as the issue is naturally resolved by the system. (Example – When entering claims, the client is not listed so the CLTC number is entered. The claim has an A1 exception because the service if not authorized. If the service becomes authorized, the exception code no longer appears.)

Some exceptions do not keep the claim from submitting to MMIS if there are no other issues with the claim (exception with "Yes" in the Submit to MMIS column below). Others (marked "No") cannot be submitted to MMIS for payment until or unless the information on the claim is updated. Updates that can be made by the provider using are specified in the Claims Resolution Process section of this manual.

Others exceptions that prevent submission for payment are resolved when additional information is given to Care Call. These include A1 (No authorization to match service delivery). For this exception, you should contact the CLTC office if you believe the exception is not warranted. CLTC can add an authorization to cover the visit if warranted.

Many exceptions are not applicable for Telemonitoring providers and are so marked in the Comments column below.

Symbol	Definition	Submitted to MMIS	Comments
A1	No authorization to match service delivery	No	
A2	Service Not Performed	No	Not applicable
A3	Client is authorized for a different Day	No	Not applicable
A4	Client is authorized for a different service	No	Not applicable
B	Non-authorized service period	Yes	Not applicable
C1	No check-in but checkout exists	No	Not applicable
C2	No checkout but a check-in exists	No	Not applicable
D	Daily units provided less than units authorized	Yes	Not applicable
E	Daily units provided exceed units authorized	Yes	Not applicable
F	Weekly hours worked more than hours authorized	Yes	Not applicable

G1	Check-in and checkout phone numbers do not match authorized	Yes	Not applicable
G2	Checkout phone number does not match authorized	Yes	Not applicable
G3	Check-in phone number does not match authorized	Yes	Not applicable
G4	Check-in and checkout phones match other client or provider	Yes	Not applicable
G5	Checkout phone number matches different client or provider	Yes	Not applicable
G6	Check-in phone number matches different client or provider	Yes	Not applicable
I1	Worker entered is not registered to perform service	No	Not applicable
I2	Worker is not registered	No	Not applicable
M	Missing Data	No	Not applicable

7.2 Exception Codes after Claims Resolution Process

As explained in the Claims Resolution Section of this manual, providers and CLTC staff perform claims resolution activities via the web. There are two steps to the process,
1. The provider adds old claims, specifying the reason, and submits it to CLTC for review.
2. After review, CLTC may accept the added claim and submit it for payment or deny the claim.

Using the Resolution report, the provider can review CLTC's determination of these claims:
- If CLTC accepts the provider's addition, it will be assigned a claim number.
- If CLTC denies the provider's addition, the resolution will be marked denied and the claim will not be entered.

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